Senate Budget & Fiscal Review

Senator Wesley Chesbro, Chair

Subcommittee No. 3
on
Health, Human Services, Labor, & Veterans Affairs

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Room 4203

Item	*Description*
4440	**Department of Mental Health** • **Community Based Services** • **State Hospitals**

PLEASE NOTE: **Only those items contained in this agenda will be discussed at this hearing. Issues pertaining to the DMH may be reviewed again at the Subcommittee's "OPEN" issues hearing and again at the time of the May Revision.** ***Please*** **see the Senate File for dates and times of subsequent hearings**.

Issues will be discussed in the order as noted in the Agenda.

Issues pertaining to the housing and treatment of Sexually Violent Predators, with the exception of the Coalinga facility, will be discussed at a later hearing.

Item 4440--DEPARTMENT OF MENTAL HEALTH

A. BACKGROUND OVERALL

Purpose and Description, including the Role of County Mental Health

Department: The Department of Mental Health (DMH) administers state and federal statutes pertaining to mental health treatment programs. **The department directly administers the operation of four State Hospitals**—Atascadero, Metropolitan, Napa and Patton--, and acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison. The department provides hospital services to civilly committed patients under contract with County Mental Health Plans (County MHPs) while judicially committed patients are treated solely using state funds.

County Mental Health Plans: **Though the department sets overall policy for the delivery of mental health services, County Realignment revenues are currently the largest revenue source for community mental health services in California. Counties (i.e., County Mental Health Plans) have the primary funding and programmatic responsibility for the majority of local mental health programs as prescribed by State-Local Realignment statutes enacted in 1991 and 1992.**

Specifically, County Mental Health Plans are responsible for:

(1) All mental health treatment services provided to low-income, uninsured individuals with severe mental illness, within the resources made available;

(2) The Medi-Cal Mental Health Managed Care Program;

(3) The Early Periodic Screening Diagnosis and Testing (EPSDT) Program for adolescents;

(4) Mental health treatment services for individuals enrolled in other programs, including special education, CalWORKs, and Healthy Families.

Overall Budget of State Department and County Funds

The budget proposes expenditures of **$2.5 billion ($910.7 million General Fund) for mental health services, including state support. This reflects a *net* increase** of $165.9 million ($31.7 million General Fund) over the revised 2003-04 budget. As noted in the table below, $1.8 billion is for local assistance, $735.6 million is for the State Hospitals, and $7 million (General Fund) is for state mandated local programs.

In addition, it is estimated that almost **$1.128 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget.** Counties use these revenues to provide necessary mental health care services to Medi-Cal recipients, **as well** as indigent individuals.

Realignment revenues are currently the largest revenue source for community mental health services in California. The second largest revenue source is federal Medicaid (Medi-Cal) dollars. Most of the state's General Fund support is expended on state-operated State Hospitals in order to serve Penal Code related patients.

Summary of Expenditures (dollars in thousands)	2003-04	2004-05	$ Change	Percent Change
Program Source:				
Community Services Program	$1,672,199	$1,807,088	$134,889	8
Long Term Care Services	704,631	735,631	$31,000	4.4
State Mandated Local Programs	6	7	1	16.6
Total, Program Source	**$2,376,836**	**$2,542,726**	**$165,890**	**6.9**
Funding Source				
General Fund	$878,929	$910,658	$31,729	3.6
Federal Funds	61,993	61,917	(76)	(.1)
Reimbursements	1,432,942	1,567,332	134,390	9.3
Traumatic Brain Injury Fund	1,575	1,422	(153)	9.7
CA State Lottery Education Fund	1,397	1,397	0	0
Total Department	**$2,376,836**	**$2,542,726**	**$165,890**	**6.9**

B. ISSUES FOR VOTE ONLY (Items 1 Through 3)

(A "yes" vote for this section means adoption of the Subcommittee recommendation as noted in the agenda discussion for each item below.)

1. Adjustments for San Mateo Field Test Model

Background and Governor's Proposed Budget: The San Mateo County Mental Health Department has been operating as the mental health plan under a federal Waiver agreement and state statute as a "field test" since 1995. The field test is intended to test managed care concepts which may be used as the state progresses toward consolidation of specialty mental health services and eventually, a capitated or other full-risk model. As the model has matured and evolved, additional components have been added and adjusted.

The budget proposes an increase of $3.3 million (Reimbursements from the DHS) to reflect an adjustment to the funding levels for this project. This adjustment is needed to reflect (1) the trend factor for pharmacy (nine percent increase), **(2)** the adjustment in the federal fund cost sharing ratio (from 53.3 percent to 50 percent) for the state's Medicaid (Medi-Cal Program), and **(3)** the adjustment needed to account for the shift from accrual to cash in last year's budget.

Subcommittee Staff Comment and Recommendation--Adopt: The budget proposes adjustments which reflect the existing agreement (i.e., Waiver for this Field Test model) the state has with San Mateo. **As such, it is recommended to adopt the budget proposal.**

2. Pre-admission Screening and Resident Review for Mental Illness (PASRR/MI)

Background and Governor's Proposed Budget: Federal law (OBRA of 1987) established each state's responsibility for evaluating persons seeking admission to or residing in nursing facilities for level of care and service needs. The DMH is responsible for administering a contract with an agency that is independent of the state and nursing home industry for the purpose of clinically evaluating each person admitted to or residing in a nursing facility if that person has mental illness. Litigation regarding the design and implementation of the evaluation instrument for this purpose has subsequently occurred.

The budget proposes an increase of $1.9 million ($470,000 General Fund) to fund expenditures associated with a pending Settlement Agreement (Charles Davis vs CA Health and Human Services Agency) regarding PASRR/MI. Of this amount, about $1.5 million would be used for a contractor and the remaining amount is for information-related technology costs. According to the DMH, this funding will support substantial revisions to the evaluation instrument, the training manual and related items.

Subcommittee Staff Comment and Recommendation--Adopt: Subcommittee staff has no issues regarding this proposal and recommends to **adopt the budget proposal**.

B. ISSUES FOR VOTE ONLY *(Continued)*

3. Governor's Proposed Repeal of Residential Care Mandates

Background and Governor's Proposed Budget: SB 155, Statutes of 1985, was enacted to address issues regarding the rates paid to private residential care facilities. According to the DMH, supplemental payments were provided for this purpose in 1989-90 and 1990-91. Then, beginning in 1991-01 (the first year of Realignment), the entire mandate was suspended pursuant to Section 17851 of the Government Code. **The DMH states that the funding that had supported the supplemental payment was included in Realignment and the counties now had the option as to how to spend these dollars. The mandate has remained suspended since this time. No other funding has been provided for this purpose.**

The Governor's budget proposes trailer bill language to eliminate the language that remains in the Welfare and Institutions Code (See Hand Out).

At this point in time it is unclear from the Administration as to whether the elimination of the Welfare and Institutions Code section regarding this issue is even needed since the provision was subsumed under Realignment.

Subcommittee Staff Comment and Recommendation—Delete: Trailer bill language is permanent statutory change that **is needed to implement the Budget Bill. The Administration's proposal is not needed to implement the Budget Bill.** No General Fund savings are identified for the action and it appears that the necessity for the language is as yet, unclear. In either case whether the language is desired for "clean-up" purposes or not, the proposal is not budget-related.

As such, it is recommended to delete this request from the budget and to direct the Administration to introduce a policy bill on the matter.

II. DISCUSSION ITEMS--Community-Based Mental Health Services

Summary of Funding for Community-Based Mental Health Services

Realignment revenues are currently the largest revenue source for community-based mental health services in California. The second largest revenue source is federal Medicaid (Medi-Cal) dollars.

The state's budget proposes expenditures of $1.807 billion (total funds) for community-based local assistance, including Medi-Cal Mental Health Managed Care, Early Periodic Screening Diagnosis and Treatment Program (EPSDT), applicable state support, the Conditional Release Program and related community-based programs. This reflects a *net* increase of $134.9 million (total funds) as compared to the revised 2003-04 budget. **This increase is primarily due to caseload and utilization of services adjustments in the baseline EPSDT Program and Mental Health Managed Care, as well as an adjustment to the San Mateo Field Test Project.**

Realignment Funding: In addition, it is estimated that $1.128 billion will be available in the Mental Health Subaccount (County Realignment Funds) which does not directly flow through the state budget. This estimate is based on the following revenue estimates:

- Sales Tax $834,609,000
- Vehicle License Fee Account $279,108,000
- Vehicle License Fee Growth Account $14,541,000
- Sales Tax Growth Account $-0-

Realignment revenues deposited in the Mental Health Subaccount, as established by formula outlined in statute, are distributed to counties until each county receives funds equal to the previous year's total. Any realignment revenues above that amount are placed into a growth account. The first claim on the distribution of growth funds are caseload-driven social services programs. Any remaining growth (i.e., "general" growth) in revenues is then distributed according to a formula in statute.

As discussed in a recently released report on mental health realignment (AB 328 Realignment Data, Department of Mental Health, February 5, 2003), due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced.

Concerns with Lack of Growth Funds: As discussed in a recently released report on mental health realignment (AB 328 Realignment Data, Department of Mental Health, February 5, 2003), **due to continued caseload growth in Child Welfare services and Foster Care, as well as cost increases in the In Home Supportive Services (IHSS) Program, growth distributions to the Mental Health Subaccount and Health Subaccount have been substantially reduced. This is because the first claim on the Sales Tax Growth Account goes to caseload-driven social services programs, not the Mental Health Subaccount.**

1. Early Periodic Screening Diagnosis and Treatment (EPSDT) Program—Significant Changes Proposed---ISSUES "A" Through "C"

Background—Overall: **Most children receive Medi-Cal services through the EPSDT Program**. Specifically, EPSDT is a federally mandated program that requires states to provide Medicaid (Medi-Cal) **recipients under age 21 *any* health or mental health service that is medically necessary** to correct or ameliorate a defect, physical or mental illness, or a condition identified by an assessment, **including services not otherwise included in a state's Medicaid (Medi-Cal) Plan.**

Though the DHS is the "single state agency" responsible for the Medi-Cal Program**, mental health services including those provided under the EPSDT, have been delegated to be the responsibility of the Department of Mental Health (DMH)**. Further, **counties are responsible for providing, arranging and managing Medi-Cal mental health services under the supervision of the DMH and DHS. However, eligibility and the scope of services to which eligible children are entitled, are *not* established at the local level.**

Types of Services: The state uses the term **"EPSDT supplemental services**" to refer to EPSDT services which are required by federal law **but are not otherwise covered under the state Medi-Cal Plan for adults**. **Examples of services include family therapy, crisis intervention, medication monitoring, and behavioral management modeling.**

EPSDT Litigation—State Has Settlement Agreements: In 1990, a national study found that **California ranked 50th** among the states in identifying and treating severely mentally ill children. **Subsequently due to litigation (T.L. v Belshe' 1994)**, the DHS was required to expand certain EPSDT services, including outpatient mental health services. The 1994 court's conclusion **was reiterated again in 2000 with respect to additional services (i.e., Therapeutic Behavioral Services—TBS) being mandated.**

Further in January 2004, the U.S. District Court issued an Interim Order clarifying an earlier ruling regarding the provision of TBS that also required outreach, monitoring and related provisions to ensure that children receive EPSDT services as needed. The Court agreed that TBS utilization was too low statewide and ordered the parties to collaborate to develop a plan to increase TBS approvals.

EPSDT Funding Process—Both County and State Funds Used To Draw Federal Match: The DHS and DMH **crafted an interagency agreement in 1995 to implement expanded services as required by the court.**

Generally, this *original* agreement required County MHPs to provide a "baseline" amount using County Realignment Funds (essentially a county "maintenance-of-effort**") and then the state was responsible for providing the nonfederal share of the growth in the program.**

The baseline amount is established for each county based on a formula. For 2004-2005, the baseline is $65.7 million, plus an additional 10 percent county match ($20 million for the

budget year) which was instituted in the Budget Act of 2002, for a total of $85.7 million (County Realignment Funds). The state will provide funding (via Medi-Cal) for costs above this amount (above the baseline and 10 percent match).

The General Fund dollars and accompanying federal matching funds are budgeted in the DHS and are transferred to the DMH as reimbursements. **The DMH distributes EPSDT funds to the County MHPs responsible for the provision of specialty mental health in each county. Final payment is based on cost settled actual allowable costs, or rates.**

Prevalence Rate for California: Based on a number of studies which estimate the prevalence of children exhibiting various levels of functional impairment, **it is estimated that 20 percent of children suffer from diagnosable mental disorder, and up to 13 percent of these children are estimated to be seriously emotionally disturbed. Given these estimates it is likely that between 500,000 to 1.3 million children and adolescents in California have a severe emotional disturbance.**

As a comparison, the actual statewide average EPSDT penetration rate was 5.29 percent as of 2001-02 and 5.32 percent as of 2002-03.

It should be noted that the **Little Hoover Commission's report** (October 2001) on the existing inadequacies in the children's mental health system considered the potential savings if children's mental health utilization increased by 10 percent—the estimated prevalence rate. In one year, they estimated that California would save $44 million in juvenile justice, $27 million in CYA costs, $78 million in residential treatment and $1.4 million at Metropolitan State Hospital. **A total of $110 million in savings!**

Governor's Proposed Budget Overall: Under the Governor's budget, state support for EPSDT would grow to $365 million (General Fund) in 2004-05, for an **increase of about $112 million (General Fund)** compared to the current year. **This proposed spending level takes into account several technical adjustments, as referenced below, as well as three proposals intended to slow growth in the program and to potentially limit access to EPSDT services.**

The budget proposes the following adjustments to the EPSDT Program:

Technical Baseline Adjustments in Budget (increase of $47.9 million General Fund):

- ***Accrual to Cash:*** Makes an adjustment of $27.8 million (General Fund) in the budget year to reflect the one-time only reduction from 2003-04 which pertained to shifting the Medi-Cal Program from an accrual to cash basis.
- **Federal Medi-Cal Match:** Makes an increase of $ 20.1 million (General Fund) in the budget year to reflect a reduction in the share of costs that is supported by the federal government (Medicaid federal match percentage). In 2003-04 a congressional relief package for states temporarily increased the federal cost-sharing ratio.

Governor's Reduction Proposals:

- ***"Re-Basing" Provider Rates:*** The Administration proposes to change how provider rates are calculated (referred to as "re-basing") for **savings of $60 million ($40 million General**

Fund) in the EPSDT and an additional reduction of $50 million (federal funds) for adult outpatient services. This issue is discussed below (i.e., Issue "A").

- ***EPSDT Program Audits by the DMH:*** The DMH contends that savings of $13 million ($6.4 million General Fund) can be achieved from conducting additional audits of counties and their contractors who provide mental health services. The DMH is seeking an increase of $1.7 million ($844,000 General Fund) to hire consultants to conduct this audit work. This issue is discussed below (i.e., Issue "B").
- ***EPSDT Waiver for Medical Necessity:*** As part of their overall Medi-Cal 1115 Waiver proposal, the Administration is also proposing a Waiver regarding the EPSDT Program. Though details are significantly lacking, the Administration purports to making changes to how "medical necessity" is defined with respect to EPSDT services. The DMH is seeking an increase of $472,000 ($236,000 General Fund) to hire a consultant ($300,000) and to support two new state staff. This issue is discussed below (i.e., Issue "C").

ISSUES "A" to "C" are discussed below.

ISSUE "A" for the EPSDT Program-–—Re-Basing Provider Rates

Background—Existing Rate Structure: Under the Medi-Cal Program there are reimbursement limits. Since EPSDT is a Medi-Cal Program that provides mental health specialty services, it uses different reimbursement limits than other Medi-Cal programs. In some instances County Mental Health Plans negotiate rates with providers. **In other cases, the reimbursement rate is based on the *lowest* of:**

- The **"State Maximum Allowable" cost**, as defined by the DMH and approved by the DHS and federal government;
- The provider's allowable cost; ***or***
- The provider's published charge to the general public, unless the provider is a nominal charge provider.

Most of the reimbursement provided under EPSDT is done through the State Maximum Allowable cost process.

***The State's Maximum Allowable Rate*: The existing "state maximum allowable" (SMA) rate structure is based on 1989-90 cost report data which has been updated annually using cost-of-living-adjustments.** This rate structure is contained within California's State Medicaid (Medi-Cal) Plan submitted to the federal government in 1993. **This Plan also provided that the state would update rates annually until they were "re-based in no more than three years using more current actual cost information". The DMH however has never updated these rates.**

According to the DMH, under the existing rate structure, (1) about 34 percent of all "Short-Doyle" inpatient psychiatric facilities are receiving *less* than their cost, and (2) about 11 percent of all outpatient specialty mental health services are receiving less than their cost.

Governor's Budget Proposal to Re-base Rates: The Governor's budget proposes to reduce the EPSDT Program **by $60 million ($40 million General Fund) and $25 million in federal funds for adult outpatient services.**

It should be noted that this re-basing proposal actually would reduce federal funds by *another $45 million* than assumed in the Governor's budget. However, the budget also assumes that California can obtain approval through a State Plan Amendment to obtain a *"public provider exemption"* for federal funds to be provided *above* California's State Maximum Allowable rate. The federal government has provided this type of exemption before. In essence, the federal reimbursement would be cost-based and not reliant on the State Maximum Allowable rate.

Subcommittee Staff Comment—Proposal is Flawed: **This budget proposal has caused grave concern because the proposed methodology *is fundamentally flawed.*** The proposed re-basing calculation would set the State Maximum Allowable rates based upon the average rates of each type of service using 2001-02 data, updated by COLAs to 2004-05. **However, the average rate is determined (1) after eliminating rates in excess of one standard deviation from the mean, and (2) after the top ten percent of providers with the highest rate are eliminated from the base data to afford cost containment.**

According to the DMH, under this proposed re-basing structure, (1) about 42 percent of all "Short-Doyle" inpatient psychiatric facilities would be receiving less than their cost, and (2) about 47 percent of all outpatient specialty mental health services would be receiving *less* than their cost. As such, this methodology would continually lower rates, whether justified or not.

According to mental health service experts, it is highly unlikely that productivity gains and other program efficiencies can be achieved to meet the significantly lower reimbursement rates. This is particularly true for group services such as day treatment and residential programs. **Many County MHPs have already made significant gains in productivity for individual services.**

The proposal also assumes that the cost of providing services is uniform throughout the state. **It has been well documented that rural areas and large urban areas have higher cost factors that often need to be taken into consideration.**

The bottom-line is that the Administration's re-basing proposal is simply a cost-shift to the County MHPs and/or providers when efficiencies or cost reductions cannot be made. Further, some providers are likely to discontinue services which will likely impact access.

Other potential options are available in lieu of doing the Administration's re-basing proposal.

EPSDT Rate of Growth Slow Down: It should also be noted that the rate of growth under EPSDT has shown recent signs of slowing down considerably. **The DMH January budget estimate assumed a growth rate of 16 percent, *where as recent actual data for EPSDT shows a growth rate of only 8 percent.***

Other Options Are Available: Based on conversations with the DMH and others, it appears that **other options are available** than what has thus far been proposed. **It should be noted however, that *any* option which reduces state General Fund support will result in a cost shift to the County MHPs and/or providers when efficiencies or cost reductions cannot be made.**

Some Other Potential Options for Reducing General Fund

- **Increase the share-of-cost currently paid by County MHPs** from its current 10 percent above the 2001-02 growth to a higher percentage (in lieu of re-basing proposal).
- **Re-base the State Maximum Allowable using a *different* averaging methodology**.

Strategies to Preserve Federal Funds

- **Implement the Public Provider exemption** which enables public entities to obtain increased federal funds. This requires a State Plan Amendment and federal approval.
- **Revise the Cost Settlement process** by establishing the County MHPs as the "sole provider" whereby contract providers are treated as purchased services of the Mental Health Plan. (This is similar to other managed care plans that have the ability to purchase services from individual providers as part of their network of services.

It should be noted that all of these options, like the one proposed by the Administration through the budget, are complex and have their nuisances.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please provide **an update on the status of the growth within the EPSDT Program. Is the growth in the program currently showing a slow-down?**
- **2.** Please provide a brief summary of the re-basing proposal.
- **3.** Please briefly describe other options that may be available for re-calculating the rates.
- **4.** What does the **DMH foresee as the next steps to be taken?**

Budget Issue: Does the **Subcommittee want to (1)** direct the DMH to convene **inclusive workgroups** to further discuss options and report back to the Subcommittee prior to May Revision, **(2)** reject the proposal, **(3)** adopt the Administration's re-basing proposal, or **(4)** develop another option?

ISSUE "B"--EPSDT Program Audits by the DMH

Background—Previous Cost Containment Actions: EPSDT is a federal entitlement under the state's Medi-Cal Program. Due to litigation, as discussed under the background section above, the program operates under a settlement agreement with both the state and County MHPs paying the non-federal share of the program. In the Budget Act of 2002, a 10 percent county match on the growth of the total state matching fund requirement above the 2001-02 level was implemented.

In addition, trailer bill legislation accompanying the Budget Act of 2002 required the DMH to ensure statewide application of managed care principles to the EPSDT Program. Regulations to implement this required were endorsed by the Secretary of State in November 2003. It appears that these recent changes may be having an effect on slowing the rate of growth within the EPSDT.

EPSDT Rate of Growth Slow Down: It should also be noted that the rate of growth under EPSDT has shown recent signs of slowing down considerably. **The DMH January budget estimate assumed a growth rate of 16 percent, *where as recent actual data for EPSDT shows a growth rate of only 8 percent.***

Governor's Budget Proposal and Recent Change to Proposal: The Governor proposes **an increase of $1.7 million ($844,000 General Fund) to hire contractors to conduct additional reviews and oversight of EPSDT Program expenditures, and assumes savings of $13 million ($6.5 million General Fund) from these audit efforts.**

The request for funding the contract audit staff originally assumed that over 300 legal entities that provide EPSDT services would be reviewed on a three-year cycle beginning in 2004-05. **This original proposal assumed a sample size representing almost 90 percent of the total paid claims from 2002-03. However, the DMH is now changing their selection criteria to represent either one of the following:**

- A legal entity that has expenditures of at least $500,000 plus a cost per client of $2,500 or greater **within a particular county**. **(This is suppose to result in a sample size of 21,252 records from 189 legal entities covering more than 77 percent of the total EPSDT dollars).**
- A legal entity that has expenditures of at least $500,000 plus a cost per client of $2,500 or greater **across counties**. (The DMH is presently conducting a data analysis to identify the sample size and number of legal entities involved.)

At this time it is unclear as to what methodology the DMH will be using, as well as whether a change in methodology would result in a need for less General Fund expenditure for the consultant audits.

The estimated savings level contained in the budget was derived by taking the approved claims amount from 2002-03 and dividing by three (since one-third of the entities will be audited each year), then reducing by 11 percent to reflect the dollars that will not be subject to the review. **The DMH then applied a 5.6 percent disallowance (i.e., savings level) to this amount.** This 5.6 percent rate is what was identified through recent audits conducted on Therapeutic Behavioral Services (TBS) reviews. **In essence, the estimated savings level represents about two percent of the total EPSDT Program for 2002-03, the year that will be initially audited.**

Further, the Administration's proposal assumes ***that the state will collect any disallowances directly from the County MHPs, even if a private provider is responsible for the audit exception.***

Constituency Concerns: The Subcommittee is in receipt of letters **expressing concerns with this audit proposal.**

The County Mental Health Directors note that they have no objection to the state fulfilling is obligation to ensure that state and federal funds are being spent appropriately under the EPSDT Program, but they question several aspects of the proposal. **First,** extrapolating limited audit findings across all claims is not consistent with generally accepted accounting principles. **Second,** the criteria for conducting these additional audits has yet to be defined. **Third**, the County Mental Health Plans will be held liable by the state for all recoupments (i.e., whatever the extrapolated amount is) even if the action pertains to a non-county community provider.

The California Council of Community Mental Health Agencies also acknowledges the necessity of audits to ensure services are being provided in accordance with specific and identifiable rules and regulations. **However, among other things, they raise the following concerns. First,** audits need to be based on clearly stated objective criteria made available to agencies before the services being audited have been provided. It is not reasonable to subject an agency to a financial disallowance for a service already provided and documented in a manner which an agency had no reason to believe at the time it was provided would be in violation of state rules. As such, they are advocating for new audits to be done prospectively. **Second,** since agencies are already subject to audits by County Mental Health Plans, if the state is going to audit for particular services, then agencies should not also be audited for the same services by county officials. **Third,** they express concern with the proposal for predicting in advance a yield of $13 million ($6.5 million General Fund) in savings. If audits yield savings, that should be factored into future budgets, but to calculate savings prior to the audits having been conducted assumes there are fraudulent practices when that has not as yet been shown.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. Please describe the budget proposal to conduct audits, including the audit selection process and criteria, and how the criteria will be applied.**
- **2. Please explain how the audit results will be applied to the County Mental Health Plans. What methods of recoupment will be applied?**

- **3. If the audit selection criteria**, which is a key component to determining the fiscal need for the consultant work, **is still in fluctuation**, **how do we know that the requested funding for the audit consultant is accurate?** Will a May Revision proposal be forthcoming on this issue?

Budget Issue: Does the Subcommittee **want to adopt or modify the Administration's proposal** to increase by $1.7 million ($844,000 General Fund) to hire contractors to conduct additional reviews and oversight of EPSDT?

ISSUE "C"--EPSDT Waiver for Medical Necessity, & More? *(See Hand Out)*

Governor's Proposed Budget: The **budget is requesting an increase of $472,000 ($236,000 General Fund) for administrative resources to develop a federal 1115 Medicaid Waiver for the Early Periodic Screening Diagnosis and Treatment (EPSDT) Program.**

The purpose of this waiver would be to redefine medical necessity with the intent of reducing future expenditures for children's mental health services.

DMH Letter—More Information and Proposing A Broader Review: In a very recent letter (dated Friday, March 12), the DMH states that they will be convening stakeholder workgroups as part of the overall proposal by the Administration to craft a comprehensive Medicaid 1115 Waiver. **Through these DMH convened workgroups, recommendations would be provided to the DHS as part of the Administration's overall Waiver process. The DMH intends to convene two stakeholder meetings—March 25th and April 21st. In addition there will be "pre-meetings", primarily for clients and family members, on both of these days as well.**

Attached to the letter is a **"Discussion Paper"** (See Hand Out). In this letter it notes that the Administration is **not only exploring options to increase state flexibility regarding the EPSDT Program, but also input on other potential changes to the Medi-Cal Specialty Mental Health Services benefit (i.e., Managed Care). Preliminary ideas for discussion include, *among other things*, the following:**

- Broaden sites where federal reimbursement for Medi-Cal services can be obtained, including freestanding psychiatric hospitals, and psychiatric health facilities greater than 16 beds serving adults for inpatient services;
- Replacing day treatment intensive and day rehabilitation for adults with partial hospitalization;
- Add recovery oriented consumer operated peer support services for adults at risk of repeat hospitalization;
- Eliminate federal Managed Care regulation requirements except for compliance.
- Clarify requirements and what's allowable, in terms of Medi-Cal federally reimbursable treatment/services.

Subcommittee Staff Comment and Recommendation: First, as noted in the DMH letter, the Administration is clearly exploring **a broader approach in crafting a potential Waiver** for mental health services provided under the Medi-Cal Program, ***not only*** **the EPSDT Program. Further, it is interesting that the DMH is potentially seeking broader changes to the Mental Health Managed Care Program when they are still having difficulty promulgating regulations for the enabling program (discussed under item 7, Issue C, below).**

Second, it is unclear at this point how the Administration intends to more narrowly define "medical necessity" within the EPSDT Program. Certainly, a primary intent is to reduce expenditures within EPSDT. **However if this means that many children will not receive services at all, or only when their condition is extremely severe, then overall expenditures**

for public services will probably not decrease. This is because the most common way that children enter the public mental health system is through the Child Welfare system, juvenile justice system or special education services (AB 3632 pupils). As such, other "entitlements" would need to be utilized. **In addition, studies consistently demonstrate that early intervention minimizes more serious illness, reduces more costly treatments and maximizes an individuals productivity and health. Deferring early diagnosis and treatment usually leads to disabling conditions and higher costs.**

Third, as specifics come forth from the Administration it **will be imperative for the Legislature to thoroughly discuss the policy merits of any proposal and its short-term and long-term implications for providing mental health services to children and adults with potentially disabling mental illness.** Further, the **Legislature will need to maintain legislative authority** over the program in order to preserve the integrity of the overall program and the services provided under it.

It is recommended to delete this proposal from the budget process without prejudice and refer it to the policy committee process. As such it is also recommended to delete the request **for $472,000 ($236,000 General Fund) for administrative resources to develop a Waiver proposal. Any funding request should be contained within a policy bill.**

Subcommittee Request and Questions: The Subcommittee has requested for the DMH to respond to the following questions:

- **1.** Please provide **a brief description** of the budget proposal regarding EPSDT, including a description of the Administration's process with respect to the mental health portion of the stakeholder groups.
- **2. Why is a broader focus now being taken regarding other potential changes to Medi-Cal mental health services?**
- **3. What are the timelines for the DMH portion of the process?**

Budget Issue: Does the **Subcommittee want to (1)** adopt the Subcommittee staff recommendation to refer this proposal to the policy committee process, **(2)** adopt the Administration's proposal, or **(3)** craft another option?

2. Governor Proposes To Eliminate Children's System of Care Program

Background—Children's System of Care: Existing law authorizes counties to develop a comprehensive, coordinated children's mental health service system as provided under the Children's Mental Health Services Act. **The target population includes individuals 18 years of age and under who have a diagnosed mental disorder in which the disorder results in *substantial* impairment in two or more areas (such as self care, school performance, family relationships and ability to function in the community). As noted by the DMH, the children served through the program have *complex* needs and require multi-agency services.**

The basic elements of the program include interagency coordination and collaboration, child/family-centered services, culturally competent services, and case management services. Families of the children are full participants in all aspects of the planning and delivery of services. When children with serious emotional disturbances learn to manage behavior through therapy, medication, education, rehabilitative and social services, they are more likely to stay out of trouble, improve school performance and remain stable in their living situation.

Under the program, accountability of services is required through measurable performance outcome goals. Past evaluations of the program have concluded that the program has been **very successful and cost-beneficial, including savings in service expenditures for group homes, special education, and juvenile justice.**

Existing categorical funding for Child Welfare, juvenile justice, alcohol and other drug and mental health services are highly regulated. Accompanying regulations define mandates and limitations that can create obstacles to solutions for these problems. The California Children's system of Care Program was created to address these criticisms for the system serving children with serious emotional disturbance. **It provides a small amount of vital flexible funding that supports locally designed solutions to system shortcomings.**

Legislature Historically Supportive of Program: **The Legislature has been very supportive of the program in the past**. Legislative budget augmentations to facilitate statewide expansion have included **(1)** $1.9 million in 1995, **(2)** $7.1 million in 1996, **(3)** $6 million in 1997, **(4)** $20 million in 1998 which was reduced by Governor Wilson to a total of $4 million, **(5)** $13.4 million in 1999 which was reduced by Governor Davis to a total of $2 million, **(6)** no increase by the Legislature but Governor Davis reduced by $2.1 million (General Fund), and **(7)** no adjustment by the Legislature but Governor Davis **vetoed $15.8 million ($13.8 million General Fund and $2 million federal SAMHSA block grant funds).**

In a veto message that accompanied the Budget Act of 2002, **Governor Davis directed the DMH to restructure the program to provide fuller accountability and to documented cost savings.**

Children's System of Care Outcome Measures—September 2003 Evaluation: In an evaluation published by the DMH in September 2003, results for 3,198 children were reviewed and the evaluators **found that the Children's System of Care Program is successful at helping children stay out of trouble, improve school attendance, and live at home or in another safe environment. It should be noted that the majority of the children in this evaluation had a history of juvenile justice system involvement.**

Among other things, the report sites the following key findings:

- **Staying Out of Trouble:** Following participation in the program, there were 55 percent fewer misdemeanors and 65 percent fewer felony arrests for the children. **A conservative cost savings amount of $1.3 million was identified for this component.**
- **Less Psychiatric Hospitalization Services:** The program's community-based services and supports optimize the potential for psychiatric inpatient services reduction. Over 46 percent of the children evaluated at the time of the enrollment were identified by history or initial assessment as being at risk of psychiatric hospitalization. However following participation in the program (during the six-month update period), only 10.6 percent required psychiatric hospitalization, or a reduction of 57.2 percent in need for inpatient care. **A projected cost savings estimate of $1.1 million was identified for this.**
- **In School Outcome: Children identified as having a serious emotional disturbance are more likely to miss school, fail more classes, and have lower graduation rates than other children with disabilities. The enhanced special day classes and wraparound services of the program are also used to supplement individualized education plan services.** Because services are accessible in the school setting, children are more likely to attend school. Sixty-six percent of the children evaluated at the time of enrollment into the program were identified by history or initial assessment as being at risk for poor school attendance. **According to the evaluation, over 82 percent of children identified as at risk of poor school attendance improved or are maintaining good or excellent levels of school attendance.**
- **Overall: Children's System of Care services help children manage mental health symptoms, develop emotion-management skills, learn positive social skills, and build family cohesion. The development of these skills helps children choose appropriate behaviors and avoid behaviors that lead to arrest and further juvenile justice system actions.**

Constituency Letters and Comment: The Subcommittee is in receipt of several letters expressing concern with the Governor's proposal. **They contend that without a system of care approach, many children will not have coordinated services or receive mental health services unless they are placed in a Group Home (where they become eligible for Medi-Cal), the juvenile justice system (where they have a constitutional right to mental health care), or are placed in special education (where there is a federal entitlement to mental health services). Several of the letters note that without the $20 million for the Children's System of Care Program, increased funding would be needed in many other areas.**

Governor's Proposed Budget—Eliminate All Funding: The Governor is proposing **to eliminate funding for the program-- $20 million General Fund.**

The Governor's budget summary states that…*"given the availability of a wide range of medically necessary services and large numbers of needy children and young adults receiving services under the EPSDT Program, it is no longer necessary to continue the Children's System of Care Program."* However, **no other rationale has ever been given** as to why this efficacious program is being proposed for elimination.

Constituency Comments—Grave Concerns: The **Subcommittee is in receipt of many letters expressing concern regarding the Governor's proposed elimination of this program**. The letters reference the DMH outcome data, as well as individual county successes with the program. They note that without a system of care approach these children will not have coordinated services and more importantly will not, in all likelihood, have any mental health services unless and until they are placed in a group home or juvenile justice facility. In each of these institutional settings, the cost of mental health treatment is likely to be greater than it would have been had it been provided before the children reached this level of care.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. DMH**, **Please briefly describe the results of the evaluation. Is the program producing measurable results and is it successful?**
- **2. DMH**, Please **briefly describe what data has been obtained from the counties** and what the DMH thoughts are about the data.

Budget Issue: Does the Subcommittee want to **(1)** reject the Governor's proposal to eliminate the Children's System of Care Program, **(2)** adopt the Governor's elimination, or **(3)** craft another alternative?

3. Proposed Reduction of Funding for Early Mental Health Program (Proposition 98 Funds)

Background—What is the Program: Under the Early Mental Health Initiative, the state awards grants (for up to three-years) to Local Education Agencies (LEAs) to implement early mental health intervention and prevention programs for students in Kindergarten through Third Grade. Schools that receive grants must also provide at least a 50 percent match to the funding provided by the DMH. Schools use the funds to employ child aides who work with students to enhance the student's social and emotional development.

Students in the program are generally experiencing mild to moderate school adjustment difficulties. Students must have parental permission to participate in the program. In addition, all Early Mental Health Initiative programs are required to contract with a local mental health agency for referral of students whose needs exceed the service level provided in this program.

The Early Mental Health Initiative is an effective school-based program. **It serves children experiencing school adjustment issues who are *not* otherwise eligible for special education assistance or county mental health services because the student's condition is usually not severe enough to meet the eligibility criteria in these other programs (such as the Children's System of Care Program or EPSDT services).**

Existing Funding Level and Grant Cycle: In the current year, **the program is supporting a total of 137 grants, with 73 grants being in their second-year of the three-year grant cycle, and 64 grants being in their third and final year of the cycle.**

According to the DMH, about 51 percent of the school sites funded through the program continue services for at least one year after the three-year grant cycle has ended.

Governor's Proposed Budget: The **Governor proposes to reduce by $5 million (Proposition 98/General Fund)** the Early Mental Health Initiative Program which provides mental health assistance to young children enrolled in school (K to Grade 3). **This proposed reduction would leave a remaining $5 million (Proposition 98/General Fund) to be used for the 73 existing grants that will be in their third year of the grant cycle beginning July 1, 2004. This funding will support about 168 actual sites.**

Subcommittee Staff Comment and Recommendation: Both the short-term and long-term effect of this reduction is that children with mild to moderate school adjustment problems will likely not receive services and may, as a consequence, need more intensive services later. Further, these students may end up doing poorly in school and developing other problems.

However the determining factor in continuing this program is whether the Education System is inclined to utilize Proposition 98 funds for this purpose. Since Senate Subcommittee No 1 has jurisdiction over the appropriation of Proposition 98 funds, it is recommended to refer this funding issue to that jurisdiction.

In the event Subcommittee No. 1 declines to review the issue or determines that additional funds are not available for this purpose, then the Governor's budget proposal would remain intact—an appropriation of $5 million for 2004-05.

Subcommittee Request and Questions: The Subcommittee has requested for the DMH to respond to the following questions:

- **1.** Please briefly describe the Governor's budget proposal.

Budget Issue: Does the Subcommittee want to refer this issue to Budget Subcommittee No 1?

4. Healthy Families Program Adjustments—*Supplemental Mental Health Services*

Background: The Healthy Families Program provides health care coverage and dental and vision services to children between the ages of birth to 19 years with family incomes at or below 250 percent of poverty (with income deductions) who are not eligible for no-cost Medi-Cal. Monthly premiums, based on family income and size, must be paid to continue enrollment in the program. **California receives an annual federal allotment of federal Title XXI funds (Social Security Act) for the program for which the state must provide a 34 percent General Fund match, except for supplement mental health services in which County realignment funds are used as the match.** With respect to legal immigrant children, the state provides 100% General Fund financing.

The enabling Healthy Families Program statute linked the insurance plan benefits with a **supplemental program** to refer children who have been diagnosed as being seriously emotionally disturbed (SED). The **supplemental services** provided to Healthy Families children who are SED can be billed by County Mental Health Departments to the state for a federal Title XXI match. **Counties pay the non-federal share from their County Realignment funds (Mental Health Subaccount) to the extent resources are available.**

Under this arrangement, the Healthy Families Program health plans are required to sign Memoranda of Understanding (MOU) with each applicable county. These MOUs outline the procedures for referral. It should be noted that the health plans are compelled, as part of the required Healthy Families benefit package and capitation rate, to provide certain specified mental health treatment benefits prior to referral to the counties.

Governor's Proposed Budget: The budget proposes **to increase by $3 million (federal funds and County Realignment Funds) to reflect caseload adjustments for supplemental mental health treatment services provided by the counties under the Healthy Families Program for children with intensive mental health needs.** According to the DMH, this budget estimate is based on past actual claims data and anticipated caseload for 2004-05.

Subcommittee Staff Comment: Subcommittee staff has raised no issues with this budget adjustment.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please **briefly describe the budget adjustment**.

Budget Issue: Does the Subcommittee want to adopt the budget proposal?

5. Mental Health Services Provided to Special Education Students ("AB 3632")

Background—Mental Health Services to Special Education Pupils: Federal law (PL 94-142 of 1975-- the Education for All Handicapped Children Act—and the later **Individuals with Disabilities Education Act (IDEA) mandates states to provide services to children enrolled in special education, including all related services as required to benefit from a free and appropriate education. Related services include mental health services**, occupational and physical therapy and residential placement.

In California, County MHPs are responsible for providing mental health services to students when required in the pupil's Individualized Education Program (IEP). This is because **AB 3632** (W. Brown), Statutes of 1984, **shifted responsibility for providing these services from School Districts and transferred them to the counties.**

These services are an entitlement and children can receive services irrespective of their parent's income-level. In addition, County MHPs cannot charge families for these services because the children are entitled to a free and appropriate public education under federal law.

What Mental Health Services Are Mandated: **Services to be provided, including initiation of service, duration and frequency of service, are included on the student's IEP and must be provided as indicated. Services can only be discontinued on the recommendation of the County MHP *and* the approval of the IEP team, or by parental decision.** Among other things, **mental health services** include assessments, and all or a combination of individual therapy, family therapy, group therapy, day treatment, medication monitoring and prescribing, case management, and residential treatment.

History of Funding for AB 3632 (Prior to 2003): For the past decade or so, **counties have supported** the program **through a combination of the following:**

- Categorical funding provided by the DMH as appropriated through the state budget process (was $12 million General Fund annually but was eliminated by the state in the Budget Act of 2002);
- Mandate reimbursement claims as obtained via the State Commission on State Mandates process (referred to as the SB 90 process, was suspended in the Budget Act of 2002 and the Budget Act of 2003);

- Realignment funds (only when other resources are not available due to the deferral of the mandate process as noted above); and
- Third-party health insurance when applicable, though parents can chose not to access their insurance for this purpose if they so decide (federal law).

Use of Special Education Funds—Budget Act of 2003: Through the **Budget Act of 2003, $69 million in new federal special education funds were appropriated under Item 6110 (Department of Education) for County MHPs to use to partially off-set the costs for these services.** ***However, these funds have as yet to be allocated to the counties.***

Additional Federal Special Education Funds Available: California will receive an *additional* **$139.5 million in new federal special education funds in 2004-05. The Governor's January budget proposes to expend only $74.5 million of this amount. As such, $65 million in federal funds is unscheduled at this time. Senate Budget Subcommittee No 1—the Subcommittee which directs the appropriation of funds for Education entities—will be discussing the allocation of these funds in their Subcommittee hearings.**

Constituency Concerns: The County Mental Health Directors Association states that **County MHPs provide AB 3632 mental health services to about 27,000 special education pupils for a total annual cost of about $120 million. Though the Governor's budget continues to provide the $69 million in federal special education funds, this amount is insufficient to meet the existing and ongoing need.**

There is also about $150 million to $175 million in *unpaid* SB 90 claims for this program.

This situation has created significant budgeting problems for them and is forcing many counties to significantly reduce services to indigent children and adults in order to fund this education mandate.

Senate Bill 1895 (Burton), Introduced: Senator Burton has introduced legislation regarding potential policy changes to how mental health services are provided to special education students and related administrative issues. This legislation is presently in a spot bill format with constituency group meetings presently occurring.

Governor's Proposed Budget: The budget proposes **to appropriate $69 million (federal special education funds) within the Department of Education's item for expenditure for County MHPs. This maintains the status quo from last year's Budget Act of 2003.**

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please describe **the role of the DMH in trying to work through the AB 3632 issues.**
- **2.** What is the status of the payment allocation to counties from the Department of Education?

- **3.** Please describe the recent litigation filed by San Diego and Contra Costa counties.

Budget Issue: Does the Subcommittee **want to refer this issue to Subcommittee No. 1 that has jurisdiction over the appropriation of federal special education funds?**

6. Community Treatment Facilities—Proposed Trailer Bill Language *(See Hand Out)*

Background: Chapter 1245, Statutes of 1993, established a new category of **secured** (locked and can use seclusion and restraints) **residential care for the treatment of seriously emotionally disturbed (SED) children** referred to as **"Community Treatment Facilities" (CTFs)**.

CTFs were generally created as an alternative to out-of-state placement and state hospitalization for SED children. Specifically, this model was intended to provide more intensive treatment than normally provided in a group home but less oversight than a State Hospital or acute institution.

Under the statute, **the DMH** is responsible for the development and distribution of **400 secured community-based beds** within the five Mental Health Regions (i.e., Los Angeles, Bay Area, Southern, Central and Superior).

The DSS is required to develop licensing regulations for these facilities, and the DMH is responsible for certifying them (i.e., approving that they meet program standards). Regulations to proceed with the development of the CTF beds became effective on July 1, 1998. **However, difficulties arose due to lack of clarity regarding some of the regulations, and problems with adequate funding.**

Through the Budget Act of 2001 and related legislation, an agreement was reached to provide supplemental funding **(both state (40%) and county (60%))** for CTF beds and related services until longer-term solutions could be crafted. **In addition, trailer bill legislation required the DMH and DSS to develop joint protocols for the oversight of these facilities and specifies provisions for establishing payment rates for them.**

Governor's Proposed Budget—Same Funding But Different Trailer Bill Language: The budget provides $1.2 million (General Fund) for supplemental funding for CTF beds. County Realignment funds provide an additional $1.8 million for this purpose. This funding level reflects the same amount as appropriated in prior years.

In addition, trailer bill language is proposed which would modify existing statute to make funding subject to the availability of funds in the annual state budget.

Subcommittee Staff Comment and Recommendation: Subcommittee staff concurs with the funding level proposed for this purpose in the Governor's budget. **However, it is recommended to reject the proposed trailer bill language and instead**, adopt only one language change which would simply insert the fiscal year (i.e., 3004-05) for which the supplemental rate is being paid. No other language changes would be taken.

In past years, the language specified the fiscal year, and as such, provided the Legislature with more control over the appropriation.

Subcommittee Request and Question: The Subcommittee has requested the DMH to respond to the following question:

- **1.** Please briefly describe the budget proposal.

Budget Issue: Does the Subcommittee want to reject the Administration's proposed change to the trailer bill language and instead, adopt a fiscal year change instead?

7. Mental Health Managed Care Program—ISSUES "A" & "B"

Overall Background—Overview of Mental Health Managed Care: Implementation of Medi-Cal Mental Health Managed Care has included the consolidation of Medi-Cal psychiatric inpatient hospital services ("Phase I"), which occurred in January 1995 and the consolidation of Medi-Cal specialty mental health services ("Phase II"), which occurred from November 1997 through June 1998.

These two phases of implementation consolidated the two existing Medi-Cal mental health programs (Short-Doyle and Fee-For-Service) into one service delivery system. This consolidation required a Medicaid Waiver ("freedom of choice") and as such, the approval of the federal government (i.e., HCFA, now the Centers on Medicare and Medicaid—CMS).

Under this delivery system, psychiatric inpatient hospital services and outpatient specialty mental health services, such as clinic outpatient providers, psychiatrists, psychologists, and some nursing services**, became the responsibility of a single entity, the Mental Health Plan (MHP) in each county. Medi-Cal recipients *must* obtain services through the MHP.**

The Waiver promotes plan improvement in three significant areas—access, quality and cost-effectiveness/neutrality. The DMH is responsible for monitoring and oversight activities of the MHPs to ensure quality of care and to comply with federal and state requirements.

Under this model, **MHPs generally are at risk for the state matching funds for services provided to Medi-Cal recipients and claim federal matching funds on a cost or negotiated rate basis. An annual state General Fund allocation is also provided to the MHP's.**

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

State General Fund Allocation: **The state General Fund allocation is usually updated each fiscal year to reflect adjustments as contained in Chapter 633, Statutes of 1994 (AB 757, Polanco). These adjustments have typically included, changes in the number of eligibles served, factors pertaining to changes to the consumer price index (CPI)for medical services, and other relevant cost items.**

However, **the state's allocation is contingent upon appropriation through the annual Budget Act. As such in more difficult fiscal years, state General Fund support has *not* been provided for the medical CPI, or the base level of funding has been proposed for reduction (such as this year).**

ISSUE "A"—Funding for Mental Health Managed Care

Background and Budget Act of 2003: Under the consolidated system, as referenced above, County MHPs accept a fixed amount of non-federal funds, based on the amount of resources the state was spending in 1994-95, which is suppose to be adjusted annually to reflect changes in the medical CPI and adjustments in caseload. **However, County MHPs have received no medical CPI adjustment since the Budget Act of 2000, and the Governor's proposed budget does not include this adjustment either.**

Further, in the Budget Act of 2003, a five percent reduction to General Fund support ($11 million) in the program was enacted due to the fiscal crisis. Since this was a reduction to the base funding, it is an ongoing reduction to County MHPs.

Based on the most recent estimate of expenditure data for 2001-02, of California's state share of cost for Mental Health Managed Care, County MHPs provided a 46 percent match while the state provided a 54 percent match. (Adding these two funding sources together equates to 100 percent of the state's match in order to draw down the federal Medicaid funds.)

Background—New Federal Regulations for Waiver: **New federal managed care regulations were issued in June 2002 and must be implemented by the state and MHPs by August 13, 2003.** According to the DMH, the new regulations require significant changes in the operation of the program.

Among other things, the federal regulations would require the following:

- The DMH must arrange for **annual "External Quality Reviews" (EQRs)** of the quality outcomes and timeliness of access to services covered by **each MHP** (56 MHPs—there are two MHPs that cover two counties);
- The methodology used to **reimburse the MHPs must be validated annually by a qualified actuary**. The DMH notes that **the actuarial studies may result in the need to revise current methods since the method currently used for distributing state General Fund support to the MHPs is not actuarially determined.**
- The **state must provide extensive information to clients** about the MHPs and client rights available under the Waiver, including detailed explanations of federal regulations written in a language that can be easily understood by all clients.
- **The County MHPs will be required to (a)** establish advance directive systems, **(b)** establish formal compliance plans and systems, **(c)** finalize and distribute informational materials, **(d)** comply with new administrative requirements related to provider contracts, **(e)** maintain additional documentation of the adequacy of the MHP's provider networks, **(f)**adopt formal practice guidelines, and **(g)** establish a more complex grievance and appeal system.

Generally, the state has three options for meeting the requirements of the regulations. We can either (1) fully comply, (2) request Waivers for certain provisions, or (3) restructure the existing program to meet all of the requirements.

Governor's Proposed Budget: The budget proposes a total state General Fund appropriation of $222.9 million (General Fund) for allocation to the County MHPs to assist in funding the Waiver Program.

This reflects a *net* increase of $10.3 million ($5.1 million General Fund) in the amount the state provides to the counties for Mental Health Managed Care**. No medical CPI adjustment is provided. This equates to a loss of $5.6 million (General Fund) for the County MHPs for 2004-05. A medical CPI adjustment** has not been funded since the Budget Act of 2000.

This net increase consists of the following proposed *key* adjustments:

- No adjustment for the medical consumer price index.
- Increase of $6.2 million (General Fund) for the change in the number of Medi-Cal eligibles.
- Reduction of $53,000 to reflect the one percent adjustment for inpatient growth; and
- Net reduction of $1 million (General Fund) to reflect the elimination of one-time costs associated with new federal regulations and increased costs for informing materials.

Subcommittee Request and Questions: The Subcommittee has requested for the DMH to respond to the following questions:

- **1.** Please **provide a brief description of the budget proposal, including what the fiscal effect is for not providing the medical CPI to the counties.**
- **2.** Please **provide an update on the implementation of the new federal regulations**.
- **3.** Will the **state be seeking any further adjustments**—either requesting federal relief from some of the requirements, **or** needing more General Fund support to implement the requirements—**prior to the implementation of the 2004-05 budget?**

Budget Issue: Does the Subcommittee want to hold this item "open" pending receipt of the Governor's May Revision?

ISSUE "B"—Proposed Trailer Bill to Extend Emergency Regulation Authority

Background—Emergency Regulation Authority Is Never Ending: Effective **November 1, 1997,** the DMH adopted emergency regulations for Medi-Cal Mental Health Managed Care as provided for in Section 5775 of Welfare and Institutions Code. **However, this authority was never intended to be on-going.**

Since this time, the DMH has obtained authority to continue the emergency regulations through annual Budget Act Language, including language adopted in 1998, 1999, 2000, 2001, and 2002.

In 2003, this authority was again extended for one more year, but it was done through statutory change. This authority will expire as of June 30, 2004, unless action is taken to extend this authority.

The DMH has **had two public comment periods on the emergency regulations—November 1997 to January 1998, and November-December 1999.** According to the DMH, extensive public comment was received.

Governor's Proposed Budget—Trailer Bill Language (See Hand Out): The Governor's proposed budget requests trailer bill language to **extend the emergency regulation authority to July 1, 2005.**

Subcommittee Staff Comment: **The Department of Mental Health has not had a public hearing on the proposed regulations since 1999, or almost five years ago. As such, the program has been operating under both emergency regulation authority and under the auspices of "All County Letters", which in some circumstances can be viewed as underground rule-making.**

Public discussions need to be re-convened to discuss the existing emergency regulations, as well as the newly proposed federal regulations and their potential effect on the program. Changes that are needed to implement the new federal regulations have not yet had the benefit of full public discourse.

Subcommittee Request and Questions: The Subcommittee has **requested the DMH to respond to the following questions:**

- **1.** Please provide **an update on the status of the emergency regulations for Medi-Cal Mental Health Managed Care**. **Why has the process taken so long?**
- **2.** What else needs to be done to complete the normal regulation process?
- **3.** Does the **DMH think it has the legal authority to subsume the new federal regulations under the existing emergency regulation authority** that was established in 1997? If so, please explain why**.**

8. Governor's Proposal to Eliminate Funding for Sacramento County & Others

Background and Governor's Proposed Budget: The budget proposes **a reduction of $724,000 General Fund by eliminating (1)** $416,000 for supplemental funding to Sacramento County's Psychiatric Health Facility (as established in SB 840, Statutes of 1991), and **(2)** $308,000 (General Fund) used by thirteen counties to match federal rehabilitation funds.

The funds for Sacramento were originally allocated to offset the financial burden imposed on it when the UC Davis Psychiatric unit closed in 1991**. Elimination of this supplemental funding requires trailer bill legislation.**

The thirteen counties include: Contra Costa, El Dorado, Fresno, Kern, Orange, Placer, Riverside, San Bernardino, San Diego, Sonoma, Stanislaus, Ventura, and Los Angeles. All of these counties receive a total of $20,505 each, except for Los Angeles which receives $61,515.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following question:

- **1.** Please briefly describe what the effect of the Administration's elimination of the $724,000 would mean to the counties.

Budget Issue: Does the Subcommittee want to keep this open pending receipt of the May Revision?

III. Discussion Items--State Hospitals & Other State Support Issues

STATE HOSPITAL FUNDING

Background Overall: The department **directly administers the operation of four State Hospitals—Atascadero, Metropolitan, Napa and Patton--, and acute psychiatric programs at the California Medical Facility in Vacaville and the Salinas Valley State Prison.**

As structured through the State-Local Realignment statutes of 1991 and 1992, the department provides hospital services to civilly committed patients under contract with County Mental Health Plans (County MHPs) while *judicially committed patients are treated solely using state funds.*

However, the Governor is proposing changes to this funding partnership by: (1) capping the enrollment of ISTs and NGI patients, and (2) shifting pre-commitment SVPs presently residing at the State Hospitals back to the counties. Therefore, counties would be required to fund these responsibilities using County Realignment Funds (no federal match is available for this patient population) or County General Fund revenues. *(Issues regarding proposed changes to how Sexually Violent Predators are housed and treated will be discussed in a subsequent Subcommittee hearing.)*

Perspective on State Hospital Expenditures: As noted in the table below, State Hospital expenditures vary by facility, contingent on the level of patient care needs, patient population, age of facility and design of the physical plant, and other factors.

State Hospital	2002-03 Reported Expenditures and Inpatient Days	2002-03 Daily Cost & Annual Cost
Atascadero	$146.9 million 412,700 days	$356 ($129,940)
Metropolitan	$131.9 million 278,700 days	$473 ($172,645)
Napa	$155.4 million 383,300 days	$405 ($147,825)
Patton	$165.5 million 475,600 days	$348 ($127,020)
TOTALS	**$599.7 million**	**$388 $141,620**

Summary of Overall Caseload--Primarily Penal Code: The DMH estimates a population of **4,327 patients for 2004-05 (as of June 30, 2005)** at the four State Hospitals-- Napa, Metropolitan, Patton, and Atascadero. **This patient level reflects a proposed *net* decrease of 107 patients as noted in the table below.**

Patient Type	2003-04 Revised Caseload	2004-05 Proposed Caseload	Caseload Percent By Patient Type	Difference
IST	847	815	18.8	-32
NGI	1,198	1,198	27.7	0
MDO	860	879	20.3	19
SVP	550	516	11.9	-34
Other PC	118	118	2.7	0
LPS—county	660	600	13.9	-60
PC 2684/2974	171	171	4	0
CY Authority	30	30	.7	0
Totals	**4,434**	**4,327**	**100 %**	**-107**

Of the total patient population, over 86 percent of the beds are designated for penal code-related patients and only 14 percent are to be purchased by the counties (i.e., Lanterman-Petris-Short beds), primarily Los Angeles County.

Penal Code-related patients include individuals who are classified as: (1) not guilty by reason of insanity (NGI), **(2)** incompetent to stand trial (IST), **(3)** mentally disordered offenders (MDO), **(4)** sexually violent predators (SVP), and **(5)** other miscellaneous categories as noted. **It should also be noted that based on recent patient statistics, about 62 percent of the State Hospital patients have a diagnostic category of Schizoaffective Disorder, including Paranoid Schizophrenia.**

Governor's Proposed Budget Overall: The budget proposes expenditures of **$702.4 million ($561.3 million General Fund) for the State Hospitals**, excluding state headquarters' support of $7.8 million, for a ***net* increase of about $31.6 million ($36.4 million General Fund)** over the Budget Act of 2003.

Specific issues regarding the State Hospitals and related items are discussed below.

1. Oversight Issue: Metropolitan State Hospital *(See Separate Hand Out)*

Background: Located in the City of Norwalk, Metropolitan State Hospital (MSH) **serves about 825 patients, including about 370 penal code-related patients.** It is the **only State Hospital that has a program for children (about 120-beds with a present census of about 80 children).** Adult patients are usually referred to the hospital by either the courts or County Mental Health Plans (County MHPs). Children are admitted to the hospital by County MHPs and the courts as well.

Federal Department of Justice Investigations Via the Civil Rights of Institutionalized Persons Act (CRIPA): The U.S. DOJ has recently released (both within the past year) results from **two investigations into the conditions of services provided at Metropolitan through the Adult Program and the Children's/Adolescents Program.** The investigations by the U.S. DOJ were conducted in June and July of 2002, with reports on the investigations being released in 2003.

The U.S. DOJ investigation regarding the **Children's/Adolescent Program was divided into 12 categories:** Psychiatry, Nursing, Psychology, Pharmacy, General Medical Care, Infection Control, Dental Services, Dietary, Placement, Special Education, Protection from Harm, and First Amendment and Due Process. **The investigation found *significant and wide-ranging problems* with the care and treatment of the children/adolescents, including wrong mental health diagnoses, improper medication management and not enough protection from other patients.** ***A comprehensively documented report (about 60-pages) was provided to the DMH in May 2003. Examples contained in the report include:***

- Doctors diagnosed disorders the patients did not have.
- Over medication was found to be of principal concern.
- Significant use of seclusion and restraint was identified.
- Treatment planning was insufficient.
- General medical care was found lacking.

The U.S. DOJ report for the Adult population was just recently released. **This analysis was divided into 8 categories: Integrated Treatment Planning, Assessments, Discharge Planning and Placement, Specific Treatment Services, Documentation of Patient Progress, Seclusion and Restraints, Medications, Protection from Harm, and First Amendment and Due Process. This investigation uncovered substantial deficiencies in patient assessments, treatment planning and implementation, and discharge planning.**

Similar to the previous report, the U.S. DOJ presented dozens of recommendations to remedy the deficiencies.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1.** Please describe **the primary concerns the U.S. DOJ identified for both** the Children's/Adolescent Program and the Adult Program.
- **2.** Using the Hand Out, what are the **key components the DMH has already implemented** at **Metropolitan in response to correct conditions identified in the U.S. DOJ report?**
- **3.** What key components **still need to be implemented at Metropolitan?**
- **4. Please describe the "Safety Risk Management Plan" for Metropolitan.**
- **5.** How is the **DMH involving consumers, advocates and the greater public in resolving issues at Metropolitan?**
- **6.** What are the **next steps regarding follow-up with the U.S. DOJ on Metropolitan?**
- **7. What is the DMH doing at the other State Hospitals to commence with correcting potential issues regarding care and treatment?**

Budget Issue: Does the Subcommittee want to **adopt placeholder trailer bill language to monitor and track the progress of the DMH in addressing the needs identified in the U.S. DOJ report?**

2. Forensic Conditional Release Program (CONREP) Funding Adjustments

Background: Existing statute provides for the **Conditional Release Program (CONREP)** and mandates that the **DMH be responsible for the community treatment and supervision of judicially committed patents, including Not Guilty by Reason of Insanity (NGI), and Mentally Disordered Sex Offenders (MDOs).**

CONREP, in operation since 1986, provides outpatient services to patients in the community and hospital liaison visits to patients continuing their inpatient treatment at State Hospitals who may eventually be admitted into CONREP. **CONREP services are provided throughout the state and are either county-operated *or* private/non-profit operated under contract to the DMH. The goal of CONREP is to ensure greater public protection in California communities via a system of mental health assessment, treatment, and supervision to persons placed on outpatient status.**

Funding for CONREP services is based on the number of outpatient cases and applicable State Hospital patients, and an average cost per patient for services. The Budget Act of 2003 provided a total of $15.2 million (General Fund) for about 740 patients (about $20,405 per patient).

Governor's Proposed Budget: The budget proposes an **increase of $464,000 (General Fund)** for CONREP. This request consists of **(1) an increase of $464,000 to support an increase of 22 patients at a revised cost of $21,091 per patient, (2) $105,000 to reflect the full-year cost for five additional patients who entered into the program in the current-year, and (3) $88,000 in additional costs for State Hospital liaison visits.**

The DMH states that some of these increased costs are the result of the granting of cost-of-living adjustments that were ratified in county bargaining unit contracts, costly medications and funding to meet residential needs for the increased number of patients released from the State Hospitals without resources.

Subcommittee Request and Questions: The Subcommittee has requested the DMH to respond to the following questions:

- **1. Please provide a brief description of the budget request.**
- **2. What options may be available to reduce the spiraling costs of CONREP?**

Budget Issue: Does the Subcommittee want **to adopt or modify the request to increase by $657,000 (General Fund) for CONREP?**

3. Governor's Proposed Enrollment Cap on Not Guilty by Reason of Insanity (NGI) and Incompetent to Stand Trial (IST) Patients *(See Hand Out)*

Background: State law **provides for courts to place certain mentally-ill persons in State Hospitals. The courts may determine that a defendant who has been accursed of a crime is "not guilty by reason of insanity" in cases when it finds that the defendant was insane at the time the offense was committed.** The courts may also find a person "incompetent to stand trial" when the defendant is unable to understand the nature of the criminal proceedings or assist in their own defense. Persons found by the court to be IST are not guilty of the crimes charged, but rather their criminal case is suspended until competency is regained. **In the case of either ruling, *the court* must direct the defendant to be confined in a State Hospital or a public or private treatment facility.**

According to a recent State Hospital patient census (March 10th, 2004), **there were 1,183 NGI patients** (about 27 percent) **and 883 IST patients** (about 20 percent) residing there for a total of 2,066 patients, **or almost half of the total State Hospital patients.**

Though state law enables the courts to decide placement of the defendant in either a State Hospital or a public or private treatment facility, **state mental health funding delineates the payment structure for such placements. As structured through the State-Local Realignment statutes of 1991 and 1992, the department provides hospital services to civilly committed patients under contract with County Mental Health Plans (County MHPs) while judicially committed patients placed in the State Hospitals are treated solely using state funds.**

Governor's Mid-Year Reduction and Proposed Budget: As part of his Mid-Year Reduction package, the Governor proposes **to cap enrollment in the State Hospitals for patients deemed to be NGI and IST as of January 1, 2004 for proposed savings of $361,000 (General Fund) in 2003-04, and $3.7 million (General Fund) in 2004-05. This requires statutory change.**

This proposal assumes the state will cap the NGI patient population at 1,198 patients as of January 1, 2004, and that 14 NGI patients would transfer to the counties in the budget year. The IST cap would be 847 as of January 1, 2004, and it is assumed that 32 IST patients would transfer to the counties in the budget year.

The Administration assumes that these mentally ill individuals, who often have a diagnosis of Schizophrenia, will be housed in county jails and therefore, will be funded *entirely* by county funds in lieu of existing state support.

Legislative Analyst's Office Recommendation: In her Analysis, the Legislative Analyst recommends for the Legislature to **adopt the Administration's proposed caps on NGI and IST patients but to amend in a sunset date of January 2006.** The LAO views this proposed cap as an interim action pending enactment of permanent changes that would ensure that expensive State Hospital resources are prioritized for patients who are amenable to treatment.

The LAO believes this proposal has merit because some NGI and IST patients transferred to the State Hospitals by the courts have been unwilling to accept treatment, including medications. Recent court rulings have limited the state's authority to provide such medications to individuals against their will. **Therefore under these circumstances, placing these individuals in intensively staffed treatment facilties such as State Hospitals is not the best use of limited state General Fund.**

The LAO contends that to the extent the imposition of a cap on NGI and IST populations prompted some judges to more carefully consider which offenders it transferred to State Hospitals, it is possible that this change could result in the more cost-effective use of state resources.

Constituency Letters: The Subcommittee is in receipt of several letters expressing significant concern with the proposed caps. **Most of the letters note that county jails are usually an inappropriate placement for seriously mentally ill individuals, and that it would be a violation of a patients rights, as well as state law, that guarantees access to treatment for these individuals. Further, to hold someone who is not convicted of a crime as a criminal in a prison facility instead of a medical facility would seem to be unconstitutional.**

The County Mental Health Directors Association also notes that the proposal is (1) another cost shift to the counties ,and (2) is a significant shift from the agreements crafted under the State-Local Realignment statutes of 1991 and 1992**.**

Subcommittee Staff Comment and Recommendation: This proposed policy change raises several significant issues. First, these mentally ill individuals, who often have a diagnosis of Schizophrenia, would be housed in county jails which is most likely unconstitutional. Second, it is probably unlikely that the caps would withstand a court challenge regarding denial of a patient's right to appropriate and timely mental health treatment. Third, it is likely that such a proposal would be deemed to be a local mandate on counties and the state would have to reimburse for the county jail time and possibly treatment. The potential litigation ensuing from this proposal could be significant. Finally, it should be noted that the Subcommittee has rejected other Administration proposals to enact enrollment caps. **As such, it is recommended to (1) reject this proposal and (2) to direct the DMH to report back to the Subcommittee regarding options that could be used to transition individuals from the State Hospitals to the CONREP Program.**

Subcommittee Request and Questions: The Subcommittee has requested for the DMH to respond to the following questions:

- **1.** Please provide **a brief overview of the budget proposal.**
- **2.** Could the CONREP Program be used in some instances to transition individuals from the State Hospitals to community treatment?

Budget Issue: Does the Subcommittee **want to adopt the Administration's proposal, the LAO recommendation, the Subcommittee staff recommendation, or choose another option?**

4. Activation of Coalinga State Hospital (CSH)

Background: In 2000, the state initiated steps to construct a new 1,500-bed secure mental health treatment facility—Coalinga State Hospital (CHS)—to provide the DMH with additional capacity to treat patients involuntarily committed under the Sexually Violent Predator (SVP) law. **The DMH began construction in 2001, and construction is scheduled to be completed by May 2005. The construction project will be funded by lease-revenue bonds to be sold by no later than Fall of 2004. To date, the state has committed more than $380 million for the construction and preliminary staffing of CSH.**

Other Areas Available for A Portion of Patient Caseload: Among other actions, the Legislature provided **$6.9 million (General Fund)** in the Budget Act of 2001 **to purchase modular buildings for placement at Patton State Hospital and Atascadero State Hospital and to convert program areas into temporary patient living space to accommodate up to 500 additional patients. It should be noted that additional funding for the State Hospital system to staff the 500 additional beds has not been provided to date *because the overall State Hospital population has grown significantly less than the DMH had previously projected.***

Governor's Proposed Budget: The Governor proposes **an increase of $24.9 million (General Fund) for the continued activation of Coalinga State Hospital (CHS), including $3.2 million to support recruitment and retention costs to aid in hiring personnel and $12.2 million for operating expenses and equipment.** The proposal would add almost 165 new positions for CHS in the budget year. The budget plan also requests an augmentation of about $770,000 for about 20 additional positions to activate for the first time 147 of the 500 temporary beds at Atascadero and Patton state hospitals.

Legislative Analyst Office Recommends to Delay Until March 2006: In her Analysis, the Legislative Analyst recommends that **the Legislature delay the activation of Coalinga State Hospital until March 2006 in order to achieve a one-time savings of $20.143 million (General Fund).**

The LAO contends that the state could delay the activation of CSH and still have more than sufficient capacity to meet the projected need for secure treatment beds in 2004-05 and beyond. **In light of the DMH's own projected patient population estimates, the LAO indicates that the DMH will have a surplus of about 600 beds in 2004-05 (the budget year). Specifically, the DMH has estimated it will need to house a total of 3,776 secure patients in the State Hospitals by June 2005. However, the State Hospitals have the capacity to hold up to 4,376 patients in secured treatment settings (including 500 temporary beds at Atascadero and Patton state hospitals) in 2004-05. As such, the anticipated decline in State Hospital populations and the resulting surplus of beds suggest that a delay in the activation of CHS would be possible.**

In order to ensure that the sale of the bonds for the CHS would proceed, **the LAO is also recommending the following Budget Bill Language:**

> "Provision x. In order to address the state's fiscal problems, it is the intent of the Legislature to achieve savings in the 2004-05 fiscal year by delaying some staffing and funding for activation of Coalinga State Hospital until 2005-06. It is further the intent of the Legislature that patients occupy beds at CHS no later than March 2006."

Subcommittee Request and Questions: The Subcommittee has requested the DMH and LAO to respond to the following questions:

- **1.** DMH, Please **provide a brief summary** of the CHS proposal.
- **2.** LAO, Please **present your recommendation.**

Budget Issue: Does the Subcommittee want to **(1)** adopt the LAO recommendation, **(2)** adopt the Administration's proposal, or **(3)** craft another option?

LAST PAGE OF AGENDA